

MDR Tracking Number: M5-04-0048-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on September 2, 2003.

The IRO reviewed aquatic therapy and office visits denied rendered from 11/11/02 through 11/27/02 denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On November 20, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
11/22/02	97113 x 2 units	\$176.00	\$0.00	No EOB	\$104.00	<u>MFG, Medicine Ground Rule</u> (I)(A)(9)(b), (I)(A)(10)(a)	Review of the daily flow sheet, supports delivery of service. Reimbursement is recommended in the amount of \$104.00.
	97530 x 2 units	\$132.00	\$0.00	No EOB	\$70.00	<u>MFG, Medicine Ground Rule</u> (I)(A)(9)(c), (I)(A)(10)(a) & (I)(A)(11)(b)	Review of the daily flow sheet, supports delivery of service. Reimbursement is recommended in the amount of \$70.00.
TOTAL		\$308.00	\$0.00		\$174.00		The requestor is entitled to reimbursement in the amount of \$174.00.

## ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for date of service 11/22/02 in this dispute.

This Order is hereby issued this 5<sup>th</sup> day of February 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqo

November 12, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M5-04-0048-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Physical Medicine and Rehabilitation. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### CLINICAL HISTORY

At the time of the accident on \_\_\_, this patient was a 46-year-old \_\_\_ police officer who was injured when stepping and slipping on a caliche-surfaced road. He felt the onset of lumbar and limb pain.

A lumbar MRI dated 5/22/01 revealed L4/5 disc extrusion and some nerve root impingement. Electrodiagnostic testing revealed abnormalities. During that year he had physical therapy, chiropractic treatment, TENS unit and medications. His pain continued. On 1/8/02 \_\_\_ performed lumbar discectomy surgery, and physical therapy followed. There was a continuation of pain symptoms and a second surgery on 7/3/02 that included interbody fusion with bone graft and cages at L3/4 and L4/5.

Over two month later in mid September, \_\_\_I wrote the order for six weeks of clinic exercise/aquatic therapy. This series was begun on 9/23/02. At times there was reported a rather limited tolerance of the program by the patient. He was also reportedly taught a self/home exercise program. The pool/clinic exercise visits went beyond the six weeks.

#### DISPUTED SERVICES

Under dispute is the medical necessity of aquatic therapy and office visits.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

The spinal fusion was performed in July of 2002. Two months later on 9/18/02, \_\_\_, his surgeon, referred this patient to the therapy facility for a six-week physical therapy program that included aquatics. At three times per week, there would have been a total of 18 visits. The patient apparently continued in the therapy more than the six-week period of time and indeed had 22 approved sessions of therapy.

The disputed issues concern the necessity of even more sessions. The activities listed in the billings/clinic notes are that of pool therapy and hands-on/one-on-one exercise therapy.

The reviewer finds that the approved sessions of treatment were sufficient in number. By that time, the patient should have been on a very adequate independent home exercise program. There is no evidence in the records to adequately support the need for additional sessions beyond those that were approved. There was no medical necessity for the further clinic pool/exercise sessions from 11/11/02 through 11/27/02.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,